STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the annual recertification survey and complaint investigations (#31284, #28691, #31723, and #32173) conducted on December 4, 2013, at Horizon Health and Rehabilitation Center, no deficiencies were cited in relation to complaints #28691, #31723, #32173, and #32205, under 42 CFR Part 483.13, Requirements for Long Term Care. Deficiencies were cited in relation to complaint #31284.	F 000	"This plan of correction is submitted as required under state and federal law. The submission of this plan does not constitute an admission on the part of Horizon Health & Rehab as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. The plan of correction does not constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. The plan of correction should be considered as Horizon Health & Rehab's credible letter alleging compliance."	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to assess the use of a restraint for one resident (#39) of three residents reviewed for the use of restraints. The findings included: Resident #39 was admitted to the facility on September 11, 2011, with diagnoses including Right Fractured Hip, Senile Dementia, Depression, and Psychosis. Observation on December 3, 2013, at 8:48 a.m., in the resident's room, revealed the resident seated in a wheel chair with a soft belt restraint applied across the resident's lap, and secured to	F 221	**F221** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Quarterly Physical Restraint Elimination Assessment was completed for resident #39 by the Director of Nursing on 12/5/2013. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected. 100% chart audit will be completed by 12/20/13 by Director of Nursing to ensure that a Physical Restraint Elimination Assessment has been completed for every resident with a restrictive device.	12/5/13 12/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — (X6) DATE

Michael Ward, CEO 12/20/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221			**What measure will be put in place or systemic changes made to ensure that the deficient practice will not occur.** 100% staff education on completion of quarterly restrain elimination assessment will be completed by 12/27/2013 by Director of Nursing and Staff Development Coordinator. New hire staff will be in-serviced during their orientation period and staff missing in-servicing will not be allowed to return to work 12/27/13 or after until in-servicing is completed. The Director of Nursing, Staff Development Coordinator, MDS Coordinator, and/or Medical Records Director will review every chart upon admission, and quarterly to ensure that a Physical Restraint Elimination Assessment has been completed. **How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not reoccur.** The Director of Nursing will report audit findings to the Quality Assurance Performance Improvement Committee (Chief Executive Officer, Director of Nursing, Staff Development Coordinator, Social Services Director, Business Office Manager, and Medical Director) monthly x 3 months, then PRN.	12/27/13

vision of Health Care Facilities
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Mitch Ward CEO — 12/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 1 the kickspurs on the back of the wheel chair. Medical record review of the Physical Restraint Elimination Assessment revealed the most recent restraint assessment had been completed in June 2013, with instructions to "...continue with restraint..." Review of the facility's policy, Use of Restraints, revealed, "...Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination..." Interview with Licensed Practical Nurse #3 on December 3, 2013, at 3:54 p.m., at the 400 hall nurse's station, confirmed the quarterly restraint elimination assessment had not been completed.	F 221		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279	**F279** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident #49's care plan was updated on 12/5/2013 by the MDS Coordinator to reflect incontinence and bladder training/toileting program. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected.	12/5/13

Mitchell, CEO 12/20/13

DEC 23 2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to develop a plan of care to address bladder incontinence for one (#49) of thirty-two residents reviewed. The findings included: Resident #49 was admitted to the facility on July 20, 2010, and readmitted on June 5, 2013, with diagnoses including Schizophrenia, Peripheral Vascular Disease, Dementia, and Chronic Obstructive Pulmonary Disease. Medical record review of a Referral to Rehab (rehabilitation - physical and occupational therapy) Services Department dated October 4, 2013, revealed Physical Therapy was consulted because the resident was having incontinent episodes. Medical record review of Daily Skilled Nursing Notes for the month of November 2013, revealed the resident was on a bladder training/toileting program. Medical record review of a nursing assessment dated December 3, 2013, revealed the resident required limited assistance with transfers, bathing, dressing, and grooming; was independent with eating; used a wheelchair for mobility; and was often incontinent of bladder.	F 279	100% chart review will be completed to ensure that incontinence and bladder training/toileting have been addressed on the resident's Care Plans. Audit and review was initiated by the Director of Nursing on 12/05/13 and will be completed by 12/20/13. **What measure will be put in place or systemic changes made to ensure that the deficient practice will not occur.** 100% staff education on including bladder training/ toileting/ incontinence will be completed by 12/27/13 by the Director of Nursing and/or Staff Development Coordinator. New hire staff will be in-serviced during their orientation period and staff missing in-servicing will not be allowed to return to work 12/27/13 or after until in-servicing is completed. The Inter-disciplinary Team (IDT)Members such as: Director of Nursing, Staff Development Coordinator, MDS Coordinator, Social Services Director, Activities Director and/or Medical Records will review every chart upon admission, and quarterly to ensure that incontinence and bladder training/toileting are addressed on resident's Care Plans.	12/20/13 12/27/13

Michael Ward, CEO 12/20/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279			**How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not reoccur.** The Director of Nursing will report audit findings to the Quality Assurance Performance Improvement Committee (Chief Executive Officer, Director of Nursing, Staff Development Coordinator, Social Services Director, Business Office Manager, and Medical Director) monthly.	

vision of Health Care Facilities
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Mich D Ward, CEO — 12/20/13

ATE FORM — 6899 — 2LIJ11 — If continuation sheet 1 of 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3 Medical record review of the current care plan revealed urinary incontinence and the bladder training/toileting program were not addressed. Interview with the Director of Nursing on December 4, 2013, at 10:30 a.m., in the Director's office, confirmed the care plan failed to address the resident's incontinence and bladder training/toileting program.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide finger nail care for one resident (#12) of thirty-two residents reviewed. The findings included: Resident #12 was admitted to the facility on September 15, 2005, and readmitted on October 25, 2011, with diagnoses including Dysphagia, Chronic Kidney Disease, Congestive Heart Failure, Hypertension, Dementia, and Joint Contractures. Medical record review of the Minimum Data Set (MDS) annual assessment dated October 15,	F 312	**F312** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident #12's nails were cleaned and trimmed on 12/4/2013 by Certified Nurse Aide. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected. All residents' nails will be observed to ensure they are clean and less than ¼ inch long unless resident prefers for nails to be greater than ¼ inch long. Director of Nursing, Staff Development Coordinator, or designee (RN, LPN) will observe resident fingernails for length and cleanliness daily x 1 week,	12/4/13

Mike Wand, CEO 12/20/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312			then 2x's per week for 2 weeks, monthly x 2 months, then PRN. All findings will be discussed during The Inter-disciplinary Team meeting. IDT Members include: Director of Nursing, Staff Development Coordinator, Medical Records, Social Services Director, Activities Director, and Dietary Manager. **What measure will be put in place or systemic changes made to ensure that the deficient practice will not occur.** 100% nursing staff will be educated on nail care by 12/27/13 completed by the Director of Nursing and/ or Staff Development Coordinator. **How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not reoccur.** The Director of Nursing will report observation findings to the Quality Assurance Performance Improvement Committee (Chief Executive Officer, Director of Nursing, Staff Development Coordinator, Social Services Director, Business Office Manager, and Medical Director) monthly x 3 months, then PRN.	12/27/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 4 2013, revealed the resident was severely cognitively impaired, and was totally dependent for eating, toileting, personal hygiene, and bathing. Observation on December 4, 2013, at 10:05 a.m., with the hospice Certified Nursing Aide (CNA), in the activities area, revealed the resident's finger nails were long (greater than ¼ inch over finger) and had brown debris under the nails. Interview with the CNA at the time of observation revealed the resident's nails were "badly in need of grooming". Interview with Licensed Practical Nurse (LPN) #7 on December 4, 2013, at 10:10 a.m., in the activities area, confirmed the finger nails were greater than ¼ inch long. Continued interview confirmed the resident's finger nails were long and needed to be cleaned.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure hand	F 318	**F318** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The Director of Nursing and Certified Nurses Aide applied resident #12's splints on 12/3/2013.	12/3/13

Mike Ward, CEO 12/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 5 and elbow splints were applied for one resident (#12) of thirty-two residents reviewed. The finding included: Resident #12 was admitted to the facility on September 15, 2005, and readmitted on October 25, 2011, with diagnoses including Dysphagia, Chronic Kidney Disease, Congestive Heart Failure, Hypertension, Dementia, and Joint Contracture. Medical record review of the care plan dated April 24, 2013, revealed the resident had contractures of the bilateral upper extremities, and wore elbow and hand splints 3-4 hours per day, as tolerated, to help manage contractures. Medical record review of the recap orders for September 2013, revealed elbow splints were to be worn three to four hours daily on the day shift. Medical record review of the Minimum Data Set (MDS) annual assessment dated October 15, 2013, revealed the resident was severely cognitively impaired, was totally dependent for eating, toileting, personal hygiene, and bathing; and the resident was non-ambulatory. Observation of the resident on December 2, 2013, at 10:30 a.m., 11:30 a.m., 1:30 p.m., and 3:30 p.m., revealed the resident had no hand or arm splints in place. Observation on December 3, 2013, at 7:30 a.m., 10:30 a.m., 12:30 p.m., 2:30 p.m., and 4:30 p.m., revealed the resident had no hand or arm splints in place. Interview with Licensed Practical Nurse #6 (LPN) on December 2, 2013, at 11:14 a.m., at the	F 318	**How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected. 100% chart review and observation will be completed to ensure any resident with orders for splints have the splints applied per orders. Chart review was initiated on 12/05/13 and will be completed by 12/20/2013 by the Director of Nursing. **What measure will be put in place or systemic changes made to ensure that the deficient practice will not occur.** 100% nursing staff education on splint application will be completed by Director of Nursing and/or Staff Development Coordinator by 12/27/13. New hire staff will be in-serviced during their orientation period and staff missing in-servicing will not be allowed to return to work 12/27/13 or after until in-servicing is completed. The Director of Nursing, Staff Development Coordinator, or designee(RN, LPN) will observe residents with splints daily x 1 week, twice a week x 2 weeks, monthly x 2 months, then PRN.	12/20/13 12/27/13

Mitch Dean, CEO 12/20/13

DEC 23 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 6 nurses' station, revealed the resident had bilateral contractures of the hands and arms. Continued interview revealed the resident, at one time, wore hand and arm splits. Continued interview revealed the resident no longer wore the splints. Interview with Director of Nursing (DON) on December 3, 2013, at 2:45 p.m., in the DON's office, confirmed no physician's order had been written to discontinue the splints and the resident was to have the splints on daily.	F 318	**How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not reoccur.** The Director of Nursing will report observation findings to the Quality Assurance Performance Improvement Committee (Chief Executive Officer, Director of Nursing, Staff Development Coordinator, Social Services Director, Business Office Manager, and Medical Director) monthly x 3 months, then PRN.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview, and review of manufacturer's recommendations, the facility failed to apply the soft belt restraint per the manufacturer's recommendations for one resident (#39) of three residents reviewed for restraints. The findings included: Resident #39 was admitted to the facility on September 11, 2011, with diagnoses including	F 323	**F323** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The Director of Nursing immediately applied resident #39 soft belt restraint according to manufactures guidelines on 12/4/2013. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected. The Director of Nursing or designee (RN, LPN) observed all other residents with soft belt restraints on 12/4/2013 to ensure the soft belt restraints were applied according to manufactures guidelines.	12/4/13

Michael Ward, CEO 12/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7 Right Fractured Hip, Senile Dementia, Depression, and Psychosis. Observation on December 3, 2013, at 8:48 a.m., in the resident's room, revealed the resident seated in a wheel chair with a soft belt restraint applied across the resident's lap. Continued observation revealed the strap on the soft belt was draped across the right arm rest and secured to the kick spur on the back of the wheel chair. Interview with Certified Nurse Aide (CNA) #6 on December 3, 2013, at 8:52 a.m., in the resident's room, confirmed the soft belt restraint had not been applied correctly. Observation on December 3, 2013, at 7:20 p.m., in the resident's room, revealed the resident seated in the wheelchair with a soft belt restraint in place across the resident's lap. Continued observation revealed the straps to the soft belt were draped under the arm rest, across the side panels on the chair, and secured to the corresponding kick spurs on the back of the wheel chair. Interview with CNA #7 on December 3, 2013, at 7:20 p.m., in the resident's room, confirmed the soft belt restraint had not been applied correctly. Review of the manufacturer's Application Instructions: Chair, revealed, "...2. Lay the lap belt across the patient's thighs with the foam facing in. 3. Bring the ends of the connecting straps down at a 45-degree angle between the seat and the wheelchair sides...Criss-cross the straps behind the chair and draw them around the opposite side kick spurs..."	F 323	**What measure will be put in place or systemic changes made to ensure that the deficient practice will not occur.** Staff education initiated on 12/5/13 and will be completed by 12/27/13 by the Director of Nursing and/ or Staff Development Coordinator of proper application of soft belt restraints according to manufactures guidelines. New hire staff will be in-serviced during their orientation period and staff missing in-servicing will not be allowed to return to work 12/27/13 or after until in-servicing is completed. Director of Nursing, Staff Development Goordinator, or designee will observe residents will soft belt restraints daily x 1 week, twice a week x 2 weeks, monthly x 2 months, then PRN. **How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not reoccur.** The Director of Nursing will report observation findings to the Quality Assurance Performance Improvement Committee (Chief Executive Officer, Director of Nursing, Staff Development Coordinator, Social Services Director, Business Office Manager, and Medical Director) monthly x 3 months, then PRN.	12/27/13

Michael Ward, CEO 12/20/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 Interview with the Director of Nursing (DON) on December 4, 2013, at 8:45 a.m., in the administrator's office, confirmed the soft belt restraint had not been applied according to manufacturer's instructions.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the Reach-In cooler temperature at or below 41 degrees Fahrenheit (F); failed to provide a sanitary environment in the food preparation area; and failed to store equipment in a sanitary manner in the Dietary Department. The findings included: Observation of the dietary department on December 2, 2013, from 7:30 a.m. until 8:00 a.m., revealed: 1. The Reach-in cooler was at 50 degrees Fahrenheit; 2. An employee bottle of water was sitting opened on the food preparation table;	F 371	**F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/ SERVE-SANITARY** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The reach-in cooler was repaired 12/02/13 by Maintenance Department. The employee's water bottle was immediately removed on 12/2 /13. The food processor was taken immediately and rewashed, dried, then stored on 12/2 /13. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected. All Dietary staff was in-serviced on 12/06/13 by the Dietary Manager about not putting personal food/drinks on food preparation table.	12/2/13 12/6/13

Mick Ward, CEO 12/20/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371			All Dietary staff were in-serviced on 12/06/13 by the Dietary Manager about the inappropriate storage of the food processor or other Dietary equipment when wet. Dietary Manager or designee (Dietary Assistant Manger, Cook, Dietary Aid) will audit food preparation table and dietary equipment for proper usage and storage daily effective 12/6/13. **What measure will be put in place or systemic changes made to ensure that the deficient practice will not occur.** The Dietary Manager and or designee,(Dietary Assistant Manager, Cook or Dietary Aide), will monitor daily and will reflect on checklist the findings, beginning 12/6/13. **How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not reoccur** The Dietary Manager will bring dietary audit form and findings to the Quality Assurance Performance Improvement Committee meeting monthly, for (3) months and then PRN, if needed. Dietary Manager or Designee will audit the reach-in cooler temperature, personal food/drinks on food preparation table and not storing the food processor wet, daily x (1) week, twice weekly x (2) weeks and monthly for (2) months. The Quality Assurance Performance Improvement Committee members are the Administrator,	12/6/13

vision of Health Care Facilities
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Michael Wood, CEO | 12/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 9 3. The food processor was stored wet, and available for use. Interview with the Assistant Dietary Manager on December 2, 2013, at 8:00 a.m., in the dietary department, confirmed the reach-in cooler was not at the appropriate temperature, employee drinks were not to be in the food preparation area, and the food processor was not to be stored wet.	F 371	Director of Nursing, Staff Development Coordinator, Social Services Director, Maintenance Director, Business Office Manager, Dietary Manager and the Medical Director.	
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to dispose of garbage and refuse properly to maintain sanitary conditions. The findings included: Observation of the garbage and refuse dumpster on December 2, 2013, from 8:00 a.m. until 8:10 a.m., revealed two dumpsters each with a side door partially opened. Further observation revealed refuse was hanging out of the two open side doors. Interview with the Assistant Dietary Manager on December 2, 2013, at 8:15 a.m., at the dumpster, confirmed the side doors of the dumpster were not closed and refuse was not contained.	F 372	**F 372 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The dumpster refuse was properly placed inside the dumpster and the doors were immediately closed to maintain sanitary conditions. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected. The Dietary Manager or Designee-(Assistant Dietary Manager, Cook or Dietary Aide), will monitor dumpster doors (3) x daily for (2) weeks, twice weekly for (2) weeks and monthly for (2) months for proper closure.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

mich Ward, CEO 12/20/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 372			**What measure will be put in place or systemic changes made to ensure that the deficient practice will not occur.** The Dietary Manager or designee,(Dietary Assistant Manager, Cook, Dietary Aide), will audit the dumpster daily x 3 to ensure refuse is properly placed and the dumpster doors are closed. **How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not reoccur** The Dietary Manager will bring Dumpster check list to the Quality Assurance Performance Improvement Committee meeting monthly, for (3) months and then PRN, if needed. The Quality Assurance Performance Improvement Committee members are the Administrator, Director of Nursing, Staff Development Coordinator, Social Services Director, Maintenance Director, Business Office Manager, Dietary Manager and the Medical Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 10 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow its protocol to document the placement of a pain patch for one (#6) of thirty-two residents reviewed. The findings included: Resident #6 was admitted to the facility on February 24, 2011, with diagnoses including Dementia, Anxiety, Psychosis, Hypertension, Congestive Heart Failure, Cerebrovascular Accident, Quadriparesis (all four limbs weak), Gastroesophageal Reflux Disease, and Dysphagia (difficulty swallowing).	F 425	**F425** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The Nurse verified the placement and documented on the Medication Administration Record the placement of Fentanyl Patch on resident #6 on 12/3/2013. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected. 100% audit was on 12/9/13 completed by Director of Nursing to ensure documentation on the Medication Administration Record for Fentanyl Patch Placement Check on all residents receiving Fentanyl Patches. **What measure will be put in place or systemic changes made to ensure that the deficient practice will not occur.** 100% nursing staff education on documentation of Fentanyl Patch Placement on Medication Administration Record will be completed by 12/27/13 by the Director of Nursing and/or Staff Development Coordinator. New hire staff will be in-serviced during their orientation period and staff missing in-servicing will not	12/3/13 12/9/13 12/27/13

Michael Wood, CEO 12/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 11 Medical record review of a nursing assessment dated August 11, 2013, revealed the resident was total dependence for transfers, bathing, dressing, grooming, and positioning; was always incontinent of bowel and bladder; and received continuous tube feeding. Medical record review of physician's orders dated December 21, 2011, revealed the resident was ordered a Fentanyl (narcotic analgesic) patch 50 micrograms (mcg) per hour to be changed every seventy-two hours. Medical record review of an undated Fentanyl Flow Sheet and interview with the Minimum Data Set Coordinator (MDS) on December 3, 2013, at 1:25 p.m., in the Medical Records office, revealed the notation "...Check placement every shift..." Continued review of the Fentanyl Flow Sheet and interview revealed the flow sheet was "most likely July 2013", and 9 signatures were missing on the 7:00 a.m. - 7:00 p.m. shift, and 18 signatures were missing on the 7:00 p.m. - 7:00 a.m. shift. Medical record review of the Fentanyl Flow Sheet for August 2013, revealed 3 signatures missing on the 7:00 a.m. - 7:00 p.m. shift, and 7 signatures missing on the 7:00 p.m. - 7:00 a.m. shift. Medical record review of the Fentanyl Flow Sheet for September 2013, revealed 18 signatures missing on the 7:00 a.m. - 7:00 p.m. shift, and 20 signatures missing on the 7:00 p.m. - 7:00 a.m. shift. Medical record review of the Fentanyl Flow Sheet for October 2013, revealed 8 signatures missing	F 425	be allowed to return to work 12/27/13 or after until in-servicing is completed. The Director of Nursing, Staff Development Coordinator, or designee(RN, LPN) will audit the Medication Administration Record of all residents with Fentanyl Patches daily x 1 week, twice a week x 4 weeks, monthly. All findings will be discussed in the Inter-disciplinary Team meetings. (IDT) members include: Director of Nursing, Staff Development Coordinator, Social Services Director, Activities Director, Medical Records, and Dietary Manager. **How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not reoccur.** The Director of Nursing will report audit findings to the Quality Assurance Performance Improvement Committee (Chief Executive Officer, Director of Nursing, Staff Development Coordinator, Social Services Director, Business Office Manager, and Medical Director) monthly.	12/27/13

Mike Ward, CEO 12/20/13

DEC 23 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 12 on the 7:00 a.m. - 7:00 p.m. shift, and 18 signatures missing on the 7:00 p.m. to 7:00 a.m. shift. Medical record review of the Medication Administration Record for November 2013, revealed 3 signatures missing on the 7:00 a.m. - 7:00 p.m. shift, and 5 signatures missing on the 7:00 p.m. - 7:00 a.m. shift. Interview with the MDS Coordinator on December 3, 2013, at 1:25 p.m., in the Medical Records office, revealed there was no facility policy addressing Fentanyl and documentation of its placement each shift, but it was a facility protocol that it was to be documented each shift. Continued interview with the MDS Coordinator confirmed there were many shifts in July, August, September, October, and November 2013, where there was no documentation the placement of the Fentanyl patch was checked each shift.	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431	**F431** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** LPN #1 and LPN #2 immediately removed the expired medication from the 500/600 hall medication cart and the Secure Unit medication cart. All medication carts on 12/5/13 were checked by the Director of Nursing for the presence of expired medications.	12/5/13

Mark Wash, CEO 12/20/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 13 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure medications were within the date of expiration in two of three medication carts observed. The findings included: Observation of the 500/600 hall medication cart on December 3, 2013, at 12:30 p.m., and interview with Licensed Practical Nurse (LPN) #1, on the 500/600 hall, confirmed one bottle (half full) of Antacid Tablets with an expiration date of February 2013, and six Phenergan (nausea medication) suppositories with an expiration date of July 2013. Observation of the Secure Unit medication cart	F 431	**How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected. 100% Licensed staff education will be provided on checking and removal of expired medication from carts by 12/27/13 by the Director of Nursing and/or Staff Development Coordinator. New hire staff will be in-serviced during their orientation period and staff missing in-servicing will not be allowed to return to work 12/27/13 or after until in-servicing is completed. **What measure will be put in place or systemic changes made to ensure that the deficient practice will not occur.** . The Director of Nursing, Staff Development Coordinator, or designee(RN, LPN) will audit each medication cart for presence of expired medications daily x 1 week, twice per week x 2 weeks, monthly x 2 months, then PRN. **How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not reoccur.** The Director of Nursing will report audit findings to the Quality Assurance Performance Improvement Committee (Chief Executive Officer, Director of Nursing, Staff Development	12/27/13

Michael Ward, LEO 12/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 14 on December 3, 2013, at 12:45 p.m., and interview with LPN #2, on the Secure Unit, confirmed one bottle (half full) of Aspirin 325mg had expired on July 2013, and one bottle (full) Aspirin EC (enteric coated) opened December 2, 2013, had expired July 2013. Review of the facility policy "Expired Medication Policy" undated, revealed "...All medications should be checked for expiration date before giving a medication...all floor stock medications on the medication cart should be checked for expiration dates on a monthly basis..." Interview with the Director of Nursing (DON) on December 3, 2013, at 3:10 p.m., in the DON's office, confirmed the nurses were to check the expiration date on the medication before it was administered.	F 431	Coordinator, Social Services Director, Business Office Manager, and Medical Director) monthly x 3 months, then PRN.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

michael Ward, CEO 12/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 15 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to ensure the staff disinfected hands and did not store the ice scoop in the ice chest during ice pass for one of three halls observed; failed to follow facility policy for sanitary storage of respiratory equipment for one (#60) of thirty-two residents reviewed; and failed to implement appropriate isolation precautions for a suspected contagious illness for one (#60) of thirty-two residents reviewed. The findings included: Observation on December 2, 2013, at 7:55 a.m., on the 400 hallway, revealed Certified Nurse Aide #1 (CNA) performing an ice pass. Continued	F 441	**F441** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** CNA#1 was immediately re-educated by the Director of Nursing on the proper procedure for passing ice. On 12/4/2013 resident #60 nebulizer was covered by the Director of Nursing when nebulizer was not in use. Resident #60 no longer has diagnosis requiring isolation at this time. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected. All nursing staff will be educated by 12/27/13 by the Director of Nursing and/or Staff Development Coordinator on the proper procedure for passing ice. All nursing staff will be educated by 12/27/13 by the Director of Nursing and/or Staff Development Coordinator on the proper procedure for covering nebulizer tubing while not in use. All nursing staff will be educated by 12/27/13 by the Director of Nursing and/or Staff Development Coordinator on the proper procedure for isolating residents with infectious diseases. 100% audit and observation will be	12/4/13 12/27/13

Melba Wood, CEO 12/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 16 observation revealed CNA #1 filled two resident's water containers with ice. Continued observation revealed after filling the water containers, the CNA left the ice scoop in the ice chest. Continued observation revealed CNA #1 delivered the two water containers to the residents' rooms, and did not disinfect the hands upon leaving the residents' rooms. Review of the facility's policy Handwashing/Hand Hygiene revealed, "...facility considers hand hygiene the primary means to prevent the spread of infections...after handling soiled equipment or utensils...after contact with objects in the immediate vicinity of the resident..." Interview with Registered Nurse #1 (RN) on December 2, 2013, at 7:59 a.m., on the 400 hallway, confirmed CNA #1 was not to leave the ice scoop in the ice chest and was to disinfect hands between the residents, after handling the water containers. Resident #60 was admitted to the facility on February 13, 2013, with diagnoses including Dementia, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Hypertension, and Atherosclerotic Cardiovascular Disease. Observation during the initial facility tour on December 2, 2013, at 9:10 a.m., revealed the resident's nebulizer, used to administer Albuterol (inhalant to open airways) four times daily, was sitting uncovered, in its holder, on the bedside stand. Review of the facility policy entitled "Administering Medications Through Small Volume (Handheld) Nebulizer" revealed, "...rinse and disinfect	F 441	completed by the Director of Nursing and/or Staff Development Coordinator by 12/20/13for all residents with orders for nebulizer treatments to ensure nebulizer tubing is covered while not in use. 100% audit will be completed by 12/20/13 by the Director of Nursing and/or Staff Development Coordinator to ensure proper procedure for isolation with any residents suffering from an infectious disease. **What measure will be put in place or systemic changes made to ensure that the deficient practice will not occur.** The Director of Nursing, Staff Development Coordinator, or designee (RN, LPN) will observe all residents with orders for nebulizer treatments to ensure the nebulizer tubing is covered while not in use daily x 1 week, twice a week x 2 weeks, monthly x 2, then PRN. The Director of Nursing, Staff Development Coordinator, or designee(RN, LPN) will observe ice pass daily x 1 week, twice a week x 2 weeks, monthly x 2 months, then PRN. Orders will be reviewed daily by Director of Nursing, Staff Development Coordinator, or designee (RN, LPN) to ensure isolation has been initiated for any resident with an infectious disease requiring isolation.	12/20/13

mick Ward, CEO 12/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 17 nebulizer equipment according to facility protocol. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it..." Interview with CNA #2 on December 2, 2013, at 9:15 a.m., in the resident's room, confirmed the nebulizer was not in a plastic bag. Interview with the Director of Nursing on December 4, 2013, at 10:40 a.m., in the Director's office, confirmed nebulizers are to be kept in a plastic bag when not in use. Medical record review of the Physician's Progress Notes for resident #60 dated February 25, 2013, revealed, "...Has rash over Abd. (abdomen) ext (extremities) knees/shins, upper back ? (questionable) Scabies...will use permethrin cream will check with Pharmacy..." Medical record review of the Medication Record dated February 2013, revealed the resident received the permethrin cream on February 25, 2013, the treatment continued through March 11, 2013, and was discontinued on March 12, 2013. Review of the facility's policy, Scabies, revealed, "...Scabies is spread by skin to skin contact with the infected area, or through contact with bedding, clothing, privacy curtains and some furniture...Affected residents should remain on Contact Precautions until twenty-four hours after treatment..." Interview with the Director of Nursing in the Human Resources office on December 4, 2013, at 12:45 p.m., confirmed the resident with	F 441	**How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not reoccur.** The Director of Nursing will report audit and observation findings to the Quality Assurance Performance Improvement Committee (Chief Executive Officer, Director of Nursing, Staff Development Coordinator, Social Services Director, Business Office Manager, and Medical Director) monthly x 3 months, then PRN.	

Mich Ward, CEO 12/20/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 18 suspected scabies had not been placed in Contact Isolation as required by the facility's policy. C/O 31284	F 441		
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on review of the personnel files and interview, the facility failed to assess competency skills for three of three newly hired nurse aides reviewed. The findings included: Review of the personnel files for three newly hired nurse's aides (two hired on October 20, 2013, and one hired on November 1, 2013), revealed no documentation the nurse's aides had been assessed for skills competency. Interview with the Staff Development Coordinator on December 4, 2013, at 7:55 a.m., in the dining area, confirmed the skills competencies had not been completed for the three employees. C/O #31284	F 498	**F498** **How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** An audit was completed on all employee files by the Human Resources Director on 12/9/2013. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents have the potential to be affected. All nursing employees will have a skills check off completed by 12/27 /2013 by the Director of Nursing and/or Staff Development Coordinator. Audit will be completed by the Human Resource Director of all new hires to ensure skills check off have been completed with one week of hire.	12/9/13 12/27/13

Mick Ward, CEO 12/20/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZON HEALTH AND REHAB CENTER	811 KEYLON STREET MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 498			**What measure will be put in place or systemic changes made to ensure that the deficient practice will not occur.** Director of Nursing, Staff Development Coordinator, or designee will perform skills check offs by 12/27/13 for all members of the nursing department. Audit will be completed monthly by Director of Nursing, Staff Development Coordinator, or designee (RN, LPN, Human Resources Director) to ensure annual skills check offs have been performed. **How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not reoccur** The Director of Nursing will report audit findings to the Quality Assurance Performance Improvement Committee (Chief Executive Officer, Director of Nursing, Staff Development Coordinator, Social Services Director, Business Office Manager, and Medical Director) monthly x 3 months, then PRN.	12/27/13

vision of Health Care Facilities
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Mitch Ward, CEO — 12/20/13

ATE FORM — 6899 — 2LIJ11 — DEC 23 2013 — If continuation sheet 1 of 1